

# Proposal for Improving Screening and Follow-Through to Services for Minnesota’s Young Children

## OUR VISION

The sooner we discover the barriers that may impact a young child’s school readiness and lifelong trajectory, the sooner the child can be connected to services to help remove those barriers from the child’s path. In Minnesota, we have found that many children who arrive at Kindergarten with significant barriers to learning could have had these barriers removed years ago—if the child had had access to timely, developmentally appropriate screening services starting at birth.

Minnesota is known for our “excellent” education and health systems. Too often, however, children are not screened, or screenings are duplicated, or screenings do not result in children getting the support they need in order to thrive. As in many other disparities, the children most likely to experience gaps (missed screenings or screenings that indicate potential barriers not being connected to services) are children of color, children whose families do not speak English at home, or children completely off the radar of any program. This bold policy proposal seeks to improve Minnesota’s approach to screening and connection to appropriate services, better leveraging our already strong programs by connecting them in ways that more robustly support families and optimize developmental and health outcomes for all young children.

The goal of this proposal is to create a screening system in Minnesota that puts the child at the center of our programs, and removes silos between those programs, so that EVERY child has the same opportunities to ensure they are ready for Kindergarten and future success, ensuring that no child, regardless of race, language, economic status, or zip code is denied access to the screening and services that they desperately need in order to thrive.

## PROCESS

This draft proposal was developed over five months by a cross-sector group focused on screening from different perspectives, including education, health, and early care and education. We are now seeking input from other organizations and individuals focused on improving outcomes for young children.

Our goal is to gather feedback to improve the proposal by the end of 2019, in order to have draft legislation ready for the 2020 session.

## FOCUS

This proposal focuses on state policy recommendations to describe, coordinate, and improve the early identification of health and developmental concerns in young children, ages birth to five, especially those missed by current programs.

Successful policy will improve access to screening, referrals to evaluation and/or needed services, and “closing the loop” so children get the support they need to thrive.

## DEFINITIONS

Our working group relied on the definitions used by the Minnesota Interagency Developmental Screening Task Force, including the following:

### *Screening*

A brief, simple, universal procedure using standardized instruments that have been validated by research. Used to identify children who may be at risk for potential health, developmental, or social-emotional problems. Concerns identified in screening should be explored by more in-depth assessment/evaluation.

### *Health screening*

Includes vision, hearing, physical growth, immunization, lead, hemoglobin.

### *Developmental Screening*

Early identification of children at risk for cognitive, motor, or communication delays that may interfere with expected growth, learning and development.

### *Social-Emotional Screening*

A component of both health and developmental screening, focused on children’s ability to express/regulate emotions, form close/secure relationships and explore their environment/learn. For children under six years, social-emotional screening is synonymous with mental health screening.

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## CURRENT LANDSCAPE

There are approximately 70,000 young children in each one-year age cohort in Minnesota (*Source: 2015 American Community Survey accessed via ECLDS*). In the 2018-19 school year, school districts reported that just over 62,000 children were screened before kindergarten by any provider (District, Child & Teen Check Ups, Head Start, private health care provider, and others), with just over 28,000 children screened at age three. While we knew these data are incomplete because there is no systematic way for health care providers and districts to share screening data, they indicate that only about 45% of all three-year-olds are being screened to identify and address conditions or barriers that may impede their readiness for kindergarten.

The fortunate fact is that many infants and young children are currently screened using many tools and in many different settings. The two largest screening “programs” are conducted by health care providers and through the Early Childhood Screening program administered by local school districts. Health care providers screen children at well-child visits beginning in infancy. Developmental screening by medical providers in primary care assesses motor skills, language, emotions, memory, behavior, and social development. Identification and treatment of children who are not meeting developmental milestones before the age of three have shown to have better outcomes that benefit the individuals and their communities for a lifetime. In addition, medical providers also screen for environmental/medical factors, such as lead and hemoglobin levels, that affect brain functions and can be acted upon if found to be high or low, respectively. Early Childhood Screening is required for all children before entering kindergarten in public schools beginning at three years of age. Screening also occurs in local public health, Head Start, child welfare, early care and education, and other public programs.

To be clear, “screening” as referenced in this proposal seeks to connect results from all these different programs, in order to help Minnesotans assure that all young children get the services they need to maximize their potential. This coordination, especially including those done by medical providers starting at birth, is critical because the young mind has two unique features: pruning and plasticity. Pruning is the ability of the young brain to learn what sounds, sights and sensations are important and to make neural connections that dedicate brain function to these inputs. As part of screening, parents are guided to talk, sing, and play with their babies to promote healthy neural connections. Plasticity refers to the brain’s ability to reprogram these neural networks as circumstances change. Both of these features fade over time, with the majority of these connections being made within the first two to three years of life. Toxic stresses that negatively affect the development of brain architecture can be buffered by nurturing care giving and community supports that promote the healthy neural connections. If connections are not made by the age of 3 to 4, it becomes increasingly difficult to establish them during childhood, leading to an increase in resources required to support and educate these children now and through their lifetime.

While specifics vary by program, many commonalities in screening requirements and tools exist. However, results are rarely shared across programs, and follow-through to services is often left up to parents, rather than providers collaborating across systems to support families in connecting with needed services. This proposal focuses on improving collaboration and coordination across programs for the benefit of children and families, rather than on creating new programs or mandates.

## EVALUATION OF THE PROBLEM

The 2018 Early Childhood Program Evaluation by the Office of the Legislative Auditor (OLA) looked at just one of Minnesota’s many screening programs (Early Childhood Screening), but several of the OLA recommendations are applicable to other screening programs as well:

- The Minnesota Departments of Education, Health, and Human Services should jointly identify what would be needed to use a unique identification number for children participating in their early childhood programs.
- The Minnesota Department of Education should collect data from school districts on the number of children who are not screened.
- The Legislature should consider reviewing the statutory reimbursement rates for Early Childhood Health and Development Screening.
- The Legislature should consider broadening authority for the Minnesota Departments of Education, Health, and Human Services to share individual-level data from early childhood programs.

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## EVALUATION OF THE PROBLEM (CONTINUED)

The OLA analysis could be summarized by saying Minnesota's current screening programs don't reach all young children; we do not know which children we are missing, and we lack process (unique ID and data sharing) to make sure that children are getting the follow-up evaluation/assessment and connections to appropriate services that they need and deserve to achieve better outcomes.

Our work group recommends a shared electronic platform through which child-level data may be linked and critical information shared across approved screening programs to reduce redundancies, close gaps, increase efficiency, and improve follow-through to needed services.

## PROPOSAL FOR IMPROVEMENT

Our work group reviewed other states' models for sharing child-level data across programs for the purpose of service coordination. We identified the Rhode Island KIDSNET model as the most robust and closest to meet our goals. Using KIDSNET as a model, we propose a vision that all Minnesota children aged 0-5 years receive appropriate and timely screening and follow through to services to remove barriers to school readiness, through access to and use of screening data by authorized users. Our proposal focuses on better connections between existing screening programs and providers to make sure children receive needed support.

### ***We propose a system with three key components:***

**Unique ID:** A unique identification number for each child, to be assigned as early in a child's life as possible. The ID would be used to conduct outreach to families to connect them with screening, and to share screening results on a "need to know" basis with public programs available to more efficiently conduct assessment/evaluation and to connect children with appropriate services to create a low-barrier, cohesive system of care. We are aware that a cross-agency team is exploring Unique ID as part of Minnesota's Preschool Development Grant project, based on recommendations from the Office of the Legislative Auditor.

**Data Sharing:** Another Office of the Legislative Auditor recommendation we support is the broadening of authority for state agencies with programs serving young children to share child-level data. Our vision would limit that data sharing to include timely, appropriate sharing of screening and service use data to make sure all children are screened and the providers deliver services indicated as necessary through further evaluation/assessment and linkage to needed supports and services.

**Integrated Information System:** We support a Minnesota-specific version of the Rhode Island approach, including creating an online portal to allow carefully specified authorized users to access children's screening and service use data. Rather than centralized repository containing data from multiple organizations, we recommend a "federated" model which links such data to create reports or datasets containing only the information on a child or group of children the user has legitimate need to access for the purpose of outreach to connect children to screening, evaluation/assessment, or indicated services. Aggregate data from this system could also be used for population-level planning and evaluation.

## INITIAL SCOPE

We recommend the State build a system to achieve this vision, understanding that it makes sense to start small but ensure that the architecture of the system could accommodate inclusion of additional partners/programs over time. The chart below shows existing public programs that could be included in the integrated system. These programs each individually collect important information on many aspects of children's development, including required screening results. However, they only share those results in very limited circumstances, screenings are often duplicated, follow-up to necessary services is not always happening and we do not know which children are missed by all systems. In addition, we strongly recommend inclusion of screening data from all well-child visits, regardless of whether the child is covered by Medicaid.

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## INITIAL SCOPE (CONTINUED)

For each program, child and parent name and contact information should be included, in order to allow programs to conduct outreach to all children, including those least likely to be connected to formal systems or programs. Additionally, for each screening a child receives through an included program, the information included/linked to this system should include the screening tool used, date of screening and screening results (“pass” or “concern”), as well as any referrals made for additional evaluation and/or services and results and/or services received as a result. We would propose linking enough information to ensure families receive the support they need in accessing indicated services.

***The following existing programs should be considered for inclusion in the Integrated Information System, with phased implementation to be determined by policy makers:***

## CURRENT MINNESOTA HEALTH AND DEVELOPMENTAL SCREENING PROGRAMS / DATA

| Screening / Data by Program                   | Birth Record | Follow Along Program | Early Childhood Screening | Child and Teen Checkups / Well Child Visits | Head Start/ Early HS | Family Home Visiting | WIC        | Dentists   |
|---|--------------|----------------------|---------------------------|---|----------------------|----------------------|------------|------------|
| <b>Ages (in years)</b>                        | <b>0</b>     | <b>0-3</b>           | <b>3-5</b>                | <b>0-5</b>                                  | <b>0-5</b>           | <b>0-5</b>           | <b>0-5</b> | <b>0-5</b> |
| <b>Child &amp; parent demographic data</b>    | X            | X                    | X                         | X   | X                    | X                    | X          | X          |
| <b>Height &amp; Weight (growth over time)</b> | X            |                      | X                         | X   | X                    |                      | X          |            |
| <b>Gestational Age</b>                        | X            | X                    |                           | X   | X                    | X                    | X          |            |
| <b>Health history</b>                         |              |                      | X                         | X   | X                    |                      |            |            |
| <b>Developmental screening</b>                |              | X                    | X                         | X   | X                    | X                    |            |            |
| <b>Social-emotional screening</b>             |              | X                    | X                         | X   | X                    | X                    |            |            |
| <b>Maternal depression screening</b>          |              |                      |                           | X   |                      | X                    |            |            |
| <b>Head-to-toe physical exam (completed)</b>  |              |                      |                           | X   | X                    |                      |            |            |
| <b>Immunization review</b>                    |              |                      | X                         | X   | X                    | X                    |            |            |
| <b>Lead blood test</b>                        |              |                      |                           | X   | X                    |                      | X (some)   |            |
| <b>Hemoglobin</b>                             |              |                      |                           | X   | X                    |                      | X          |            |
| <b>Tuberculosis risk or testing</b>           |              |                      | X                         | X   | X                    |                      |            |            |
| <b>Vision screening</b>                       |              |                      | X                         | X   | X                    |                      |            |            |
| <b>Hearing screening</b>                      |              |                      | X                         | X   | X                    |                      |            |            |
| <b>Fluoride varnish application</b>           |              |                      |                           | X   | X                    |                      |            | X          |

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## PRIVACY

This system must have informed parent consent to allow sharing of data from each program. The system must be set up to be in compliance with Minnesota's data privacy and security policies, including an audit trail each time anyone accesses a child's record. In fact, a benefit of building a coordinated system would be to have a better handle on who is using the data and for what purposes. This system must only be used to support families' voluntary access to support, through outreach, screening and follow-through to services – access must not be available for any other purpose, including to build a case for Child Protection or immigration action.

## POLICY AND FUNDING IMPROVEMENT

We recommend that aggregate data from the system be analyzed regularly by the participating state agencies to assess the availability and adequacy of screening and of follow-up services. This will help guide future policy and funding decisions to ensure that children can access indicated services, in all areas of the state and appropriate to all linguistic and cultural communities' needs. It could provide critical data to evaluate and improve the efficiency and effectiveness of the screening and follow-through systems, allow us to better understand where and how to best reach and serve children at each stage of their development. Building and implementing this system will require significant resources. As part of that investment, we recommend increasing reimbursement for screenings included in this system to cover the true costs of the screening programs, including interpreter costs (when relevant).

**“Many US children enter kindergarten with limitations in their social-emotional, physical, and cognitive development that might have been significantly diminished or eliminated through early recognition of and attention to child and family needs.”**


**– American Academy of Pediatrics (July 2019)**

*Citation: Williams PG, Lerner MA, AAP COUNCIL ON EARLY CHILDHOOD, AAP COUNCIL ON SCHOOL HEALTH. School Readiness. Pediatrics. 2019;144(2):e20191766*

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## APPENDIX

### Rhode Island KIDSNET Overview



**KIDSNET** is a Rhode Island Department of Health children's health information system.

**KIDSNET** keeps track of children's vaccinations (shots) and other public health services.

**KIDSNET** provides doctors with an official immunization record when children need them for entry to school, child care, camp, and college.


**KIDSNET** helps identify children who may need certain preventive health services such as shots, lead screenings, or a hearing test.

**KIDSNET** benefits everyone by helping make sure all children receive complete preventive healthcare to keep them well.

**KIDSNET** information is private among families, their doctor, and other public health professionals who provide services to them.

The following programs are affiliated with KIDSNET:

- Newborn Screening Programs  
*Including screening for hearing, developmental risks, and inherited disease*
- Family Visiting
- Women, Infants, and Children (WIC) Nutrition Program
- Childhood Immunization Program
- Childhood Lead Poisoning Prevention Program
- Birth Defects Program
- Early Intervention Program
- Child Outreach
- Asthma
- CEDAR
- Head Start



For more information, visit [www.health.ri.gov/programs/kidsnet](http://www.health.ri.gov/programs/kidsnet) or call the Health Information Line at 401-222-5960 / RI Relay 711

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## APPENDIX

The following people participated in the effort to develop these recommendations, providing consultation and technical assistance based on their professional expertise and experience:

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*\*Work group members were not asked to officially endorse this proposal, either individually or through their organizations.*

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